Connecticut ORTHOPAEDIC Society

November 25, 2013

Victoria Veltri, JD, LLM
Office of the Healthcare Advocate
PO Box 1543
Hartford, Connecticut 06144

Dear Ms. Veltri,

The Connecticut Orthopaedic Society (COS) appreciates the opportunity to respond to the State Innovation Model (SIM) plan prepared by the Connecticut Office of the Healthcare Advocate.

Our response is based upon a thorough review of the SIM plan by members of the COS board, attendance at a recent information session, presented by the SIM outreach team and sponsored by the Connecticut State Medical Society (CSMS) for specialty care providers, and discussions with CSMS leadership and its representatives.

As you are well aware, this plan is the result of extensive efforts by government officials, public health advocates, and insurers here in Connecticut, and that the process was underwritten by a grant from the Center for Medicare and Medicaid Innovation (CMMI). Furthermore the SIM plan represents the basis for a proposed implementation grant from CMMI to be awarded in 2014.

The SIM plan highlights many of the challenges currently facing the health delivery system in Connecticut. The "triple aim" of the plan; primary care transformation, community health improvement, and consumer empowerment is likely, at least in the abstract, supported by most citizens in the state. Therefore, the COS applauds efforts by our public health officials to define and address deficiencies and disparities in the Connecticut healthcare delivery system.

At the COS, we believe that physicians caring for patients continues to be foundation of the healthcare delivery system, and therefore believe that physicians have a responsibility to advocate and work towards high quality, appropriately delivered and low cost health care. This includes physicians, based upon transparent cost and quality data, voluntarily engaging with employers, payers, and health systems to facilitate innovation in healthcare delivery. To that end, the COS feels strongly that initiatives built around consensus among all stakeholders are always better executed and better serve patients than those built around mandates.

While the SIM plan focuses on important deficiencies with the state healthcare delivery system, we have concerns not only about the process used to formulate the SIM plan but also on its substance. Our concerns are as follows:




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- **Limited input from practicing physicians.** Review of the SIM plan and the work group member lists demonstrates a notable lack of practicing physicians in the development process. This likely influenced the substance of the plan and the potential for "buy-in" from the medical community
- **Impact on specialty care not adequately addressed.** The plan focuses almost exclusively on primary care services but provides little analysis on the impact these changes will have for specialty care physicians. Leaving this analysis out of the discussion until the primary care transformation is already underway leaves many physicians and patients vulnerable to unintended consequences that will almost certainly result from this plan.
- **No consensus on definition of high value medical care.** The SIM plan assumes consensus on what constitutes high quality, clinically appropriate, low cost (high value) care. No such consensus currently exists, inside or outside the medical community. In fact, in most cases payers have proprietary ratings systems of physicians that likely emphasize cost of care over clinically valid measures of quality care.
- **Physicians are best equipped to define quality performance.** If the SIM plan is adopted, any performance metrics around quality and cost of care will need to be universal, transparent, and adopted only after they are determined to be clinically valid by the physician community. Having valid and transparent performance benchmarks and outcomes data will allow physicians, who wish to participate, the tools to make legitimate "value" based decisions
- **Inappropriate referral of patients for specialty care possible.** Without the above reforms, there is the possibility that primary care physicians and providers may be subject to financial incentives to steer patients to low cost providers and health systems, based solely on cost and not value. This is especially true if a void persists around valid quality measures. When provided with valid data, physicians will be empowered to make the best referral decisions for patients. That data is not yet available.
- **Physician incentives to limit care are possible.** The SIM plan, along with its proposed financial incentives, has the potential to corrupt the doctor-patient relationship by diverting physician attention to cost of care and away from patient care. There is no evidence provided in the plan that citizens in Connecticut are comfortable with this transformation in the doctor-patient relationship.
- **Malpractice reform not addressed.** The plan makes no attempt to address medical malpractice as a source of increased cost to the health delivery system. Defensive medicine and insurance premiums divert resources from appropriate patient care. Furthermore, the plan explicitly asks physicians to assume more "risk" for clinical and financial performance of the health system, which could result in increased legal risks as well. We feel concrete recommendations in this area needs to be included in the SIM plan.
- **There is no public mandate for this expansive reform proposal.** The plan proposes to include 80% of Connecticut citizens in a transformation of the primary care, and possibly the entirety, of the healthcare delivery system. It is not at all clear that even close to a majority of the citizens likely to be affected by this model are dissatisfied with or ill-served by the current healthcare delivery system. Those patients most likely dissatisfied with access to and quality of care, the state Medicaid population, are explicitly excluded from the proposed transformation.
- **The SIM plan is over-reaching in scope.** With 10% of the population consuming 50% of healthcare services, and the bottom 50% of the population representing just 5% of healthcare expenditures, what is rational for including 80% of Connecticut citizens in this transformation of the healthcare delivery system? Was a more targeted approach considered, or was this level of participation driven by the CMMI grant process?

- **SIM perspective on payment reform is unclear.** The foundation of our healthcare payment model continues to be fee-for-service and viable alternatives to this system do not currently exist. While ACO and bundled payment models (among others) are currently being developed to allow physicians to partner with payers and health systems, they are not currently proven substitutes for the current fee for service system. The COS believes that any efforts in payment reform should be developed as an adjunct to the current fee for service models and their adoption should be completely voluntary for both primary care and specialty care physicians alike. The COS feels that an explicit preference for the current fee-for-service as the basis for any payment reform needs to be explicitly stated in the SIM plan.
- **Patients must share financial risk related to healthcare spending.** The financial incentives of all participants in the healthcare delivery system need to be aligned, including physicians, health systems, insurers, employers and patients. Patients must share in the cost, as well as the savings related to healthcare utilization decisions. While patient risk-sharing should not be onerous or discourage necessary care, this approach facilitates the partnership between patient and physician and makes decisions more collaborative around both cost and quality. The SIM plan delves deeply into shifting financial risk towards physicians and other healthcare providers and, not surprisingly, away from payers, but says little about engaging patients in financial decisions. Furthermore, physicians who have agreed to assume risk should not be penalized by patient non-compliance with appropriate health maintenance or treatment recommendations.
- **Impact on rural healthcare, small physician groups, and solo physicians is not defined.** The SIM plan specifically employs a sophisticated health information system to facilitate cost and quality decision-making. The burden of this requirement will be out of reach for many small medical providers, many of whom disproportionately service rural communities. If these physicians must partner with large health systems to facilitate "transformation," this will have a disproportionate impact on small independent providers and rural communities.
- **Risk-sharing for healthcare systems not detailed.** If physicians come under the auspices of large health systems, either electively, or through financial necessity, what will be the mechanism to control health system (hospital) costs if physicians and their patients are effectively captured by the "system." Will there be protections for physicians and patients if "higher value" care is available outside a physician's affiliated health system? If physicians and patients choose to share in the financial risk and benefits of any payment reform mechanisms, transparency should be equally applied to healthcare systems, and freedom of choice in providers should always be paramount.

We again thank you for the opportunity to learn more about the SIM plan and for allowing the COS to provide commentary. As always, we are available to carry forward discussions on transformation of healthcare delivery in Connecticut, but do feel strongly that that discussion needs to be centered on the importance of doctor-patient relationship, valid and transparent cost and quality data for all participants in the health delivery system, alignment of financial incentives among all stakeholders, voluntary cost and utilization control programs, support for the fee-for-service payment model, malpractice reform, and voluntary participation by patients and physicians.

Sincerely,

Ross A. Benthien MD, MPH
President
Connecticut Orthopaedic Society.